ZUELLIG FAMILY FOUNDATION

Annual Report 2014

Attaining Better Health Outcomes **is Our Bottom Line**

Going where health inequities are most challenging

Partnership: Creating added value, innovating and reaching more areas

On the way to influencing the national impact

MISSION

To enhance the quality of life of the Filipino
by focusing on the achievement of targets in the country's
Millennium Development Goals for health, in partnership with
government and other stakeholders in the health sector

VISION

To be a catalyst for the achievement
of better health outcomes for the poor through sustainable
healthcare programs and services, with a primary focus on health
inequities in rural areas of the Philippines

CONTENTS

ATTAINING BETTER HEALTH OUTCOMES IS OUR BOTTOM LINE

Lilybelle Bakil is a 35-year-old mother of six living in Malacca village in Panglima Sugala, Tawi-Tawi. Her municipality became part of Zuellig Family Foundation's prototype municipalities—under Cohort 3—in 2011. In this town, among the health programs introduced to ensure better health is the use of the Wireless Access for Health (WAH) technology. With this, pregnancy cases like Lilybelle's are tracked and monitored regularly by municipal health personnel.

In the Autonomous Region in Muslim Mindanao, health is not devolved to the local government units (LGUs) unlike in the rest of the country. Despite the difference, ZFF has seen its Health Change Model remaining effective in most of its ARMM LGUs. In Panglima Sugala, there has been no maternal death since 2012. Leadership changed when then municipal mayor Nurbert Sahali was elected provincial governor in 2013. He was succeeded by his sister Rejie Sahali, who has kept health on top of her administration's priority.

2014 SNAPSHOT

525
NUMBER OF MUNICIPALITIES WITH ZFF INTERVENTIONS

28
PARTNER PROVINCES

26m
LGU population

10
ACADEMIC PARTNERS

9
Luzon

HEALTH FACILITIES FUNDED

171
faculty trained

5
Visayas

23
Completed facilities in 16 municipalities

203
DEVELOPMENT MANAGEMENT OFFICERS TRAINED

14
Mindanao

5
Ongoing construction in 4 municipalities

P1:P2.06
LEVERAGING[A]

[A] Based on ZFF's internal funds and co-financed funds (UNFPA, UNICEF, USAID, and MSD) spent, and brokered funds based on the Department of Health's approved budget for its partnership program with ZFF.

San Fernando, Camarines Sur had no functional birthing facility, so women either gave birth in Naga City's provincial hospital or in their homes. When the municipality became part of the Zuellig Family Foundation's program in 2012, Mayor Eugenio Lagasca Jr. upgraded the Rural Health Unit, funded the Basic Emergency Obstetric and Newborn Care training of health staff, and fixed the access roads leading to birthing facilities built in partnership with ZFF and Caritas. Only one village remains difficult to reach—Barangay Calascagas. Shown in photo is Mayor Lagasca as he and his health team navigate the muddy terrain to reach Calascagas for a scheduled clustered barangay health meeting.

David Zuellig • Daniel Zuellig • Washington Z. SyCip • Roberto R. Romulo, Chairman • Ernesto D. Garilao, President

Committed to better health outcomes for the rural poor

Good leadership and governance entails the inclusion of various stakeholders in discussions and policy-making to ensure popular support. These are among the key points that ZFF inculcates in its health leaders.

Esperanza I. Cabral, M.D. • Francisco R. Billano • Manuel M. Dayrit, M.D. • Kasigod V. Jamias, Treasurer • Reiner W. Gloor

Health inequities in the Philippines prompted us to find a strategy that would address systemic problems plaguing our healthcare system. That strategy, the "Health Change Model," targeted transformations in health leadership and governance. The strategy was initially met with hesitation and skepticism. But in time our decision to focus on this was proven right.

A NEED FOR BETTER LEADERSHIP AND GOVERNANCE

The year 2014 saw an Ebola outbreak in Africa that threatened the world. While this is now being contained, the response to it has been subject to criticisms.

Response to the crisis has often been described as belated, lacking and uncoordinated. In particular, critics pointed to the initial lack of leadership and governance displayed by the affected African states and the World Health Organization (WHO).

The African nations—Sierra Leone, Guinea and Liberia—are among the world's poorest and are recovering from armed conflicts. They have weak health systems characterized by lack of manpower, supplies and facilities. The populations were not well-informed about health—a major responsibility of governments. Health monitoring was lacking, such that by the time it was correctly identified as Ebola, patients have already made contact with many others. These countries are also aid-dependent, but only limited funds were funneled to strengthening health systems.

The Ebola-afflicted nations' problems mentioned earlier—lack of manpower, facilities, health monitoring and budget—mirror the challenges faced by a number of our country's municipalities. There are weak local systems that can easily be overwhelmed by epidemics and other crises. While donations and deployment of health workers offer immediate help, there need to be long-term, sustainable solutions. And this is achieved by making health systems sound and resilient. This is achieved if there is strong, accountable and informed public health leadership.

Good leadership and governance also entails the inclusion of various stakeholders in discussions and policy-making to ensure popular support. These are among the key points that our Foundation inculcates in our health leaders.

SUCCESSES AND CHALLENGES ALONG OUR JOURNEY TO LEADERSHIP TRANSFORMATIONS

Our country does not lack good public leaders. But their capacities to deal with the complexities of health systems need strengthening.

So we began our journey in 2009, a year after we formulated our strategy. And as the numbers of our partner-municipalities grew, so did the challenges we encountered. Sure we had successes, but we must also admit that in some municipalities, we continue to struggle.

In geographically isolated and disadvantaged areas (GIDAs), health problems cannot be solved completely without taking into consideration issues on education, livelihood and security. As you will see later in this report, the maternal deaths in GIDAs remain high, but we are hopeful deaths will be reduced as soon as a pro-poor health system is in place.

In the Autonomous Region in Muslim Mindanao (ARMM), where health is not devolved to local government units, good working relationships must be established not just with the municipalities but with provincial and regional health offices as well. A significant portion of the population also remains steeped in cultural practices that are unhealthy. These caused maternal death reduction in the region not to stabilize, with periods of successive decreases and then a spike like in last year's figure. We need to further drill down persistent issues and innovative interventions until we and our partners get the approach right.

Improvements, however, outweighed the setbacks. So in 2012, we were encouraged to target a third of the country's total municipalities within 10 years. That year we got the United Nations Population Fund (UNFPA) to partner with us.

The following year, we revised our targets because the Department of Health (DOH) asked us to replicate our "Health Change Model" nationwide.

BIRTHING PAINS

It was overwhelming at first. Not only did the target increase to 609, the timeframe for doing so was just three (3) years. As in any new endeavors, challenges were inevitable, but we had to move quickly.

It had not been easy. Ours is a small organization with a relatively new strategy. Our programs had to be tweaked. Our work systems had to adjust to meet the requirements of our partners. Fortunately, our people had the capacity to meet the scaling-up challenges.

The technical expertise and resources of our partners, which grew to include the Merck Sharp and Dohme (MSD), United Nations Children's Fund (UNICEF) and United States Agency for International Development (USAID), helped address the growth in LGU numbers.

Our partners had been accommodating and cooperative as well. One example is the DOH's prompt action on a need for early data reporting on maternal deaths. Academic partners, tasked to provide the training to mayors and municipal health officers under our DOH program, have been creating plans to ensure the continuity of the health leadership and governance capability-building offering beyond the term of the partnership between us and the DOH.

WAY FORWARD

As we move forward, we see our role as a catalyst for health system reforms remaining relevant in the years to come. As the Millennium Development Goals draw to a close, we have begun planning our next 10 years. But while this has not yet been finalized, we still see ourselves offering our capability-building programs to more public leaders who want to make an impact on the health of their constituents. We can pass our learning to more academic partners and institutions willing to take on the challenge of transforming health leaders.

We believe there is much room for institutions that can hone the skills of our nation's present and future leaders so they would know their way through the intricacies of health systems and good public governance.

Together with our partners, management and staff, we will remain focused on ensuring that our programs lead to concrete results—results that are felt by the poor; results that are backed by better health indicators; and results that lead to improved health outcomes of the poor.

"We believe there is much room for institutions that can hone the skills of our nation's present and future leaders so they would know their way through the intricacies of health systems and good public governance."

Going where health inequities are most challenging

A river runs through the municipality of Matuguinao, Samar. With no roads and few footpaths to connect most of the villages, residents of far-flung communities must cross rivers to reach the town center, where the Rural Health Unit is located.

Since the difficulty of accessing quality health services is shared by other municipalities in the country, the Zuellig Family Foundation has accepted the challenge of reaching these areas and helping in the transformation of their health leadership and consequently, their local health systems.

Prototyping is the Zuellig Family Foundation's (ZFF) mode of implementation in testing the effectiveness of its development strategy on selected rural municipalities. By prototyping its strategy in different sets of municipalities, the Foundation has been able to evaluate its strategy, the "Health Change Model" (HCM). The strategy's main principle revolves around health leadership transformation as the first step toward achieving better health outcomes for the poor – improved and responsive leadership means reduced health inequities.

All health leaders were closely monitored and mentored as they improved their local health systems.

When the Foundation decided to zero in on the health of the rural poor, it formulated a development change strategy that focuses on equipping mayors and municipal health officers with the knowledge and skills that would enable them to address the health inequities in their respective municipalities.

That strategy, called the "Health Change Model," was piloted in nine (9) fourth- to fifth-class municipalities in 2009. These areas were characterized by high health burdens, poorly maintained health facilities, and low community health participation — but with mayors fully committed to health reforms. They became Cohort 1.

The following year, ZFF added municipalities (Cohort 2) from priority regions where poverty incidence was highest and health indicators were poorest. These were in the regions of MiMaRoPa, Bicol, Eastern Visayas and Zamboanga Peninsula.

While ZFF continued to choose poor local government units (LGUs) that had high maternal and child health burdens, but with committed leaders, it also formed exclusive cohorts of LGUs from the Autonomous Region in Muslim Mindanao (ARMM) and the Geographically Isolated and Disadvantaged Areas (GIDAs). This came as a result of the unique challenges posed by some of the

municipalities in its first two cohorts. Cohort 1 included four ARMM municipalities from Maguindanao. The non-devolved setup required a corresponding adjustment in the interventions; hence, it decided to form a cohort composed entirely of ARMM LGUs. Cohort 3 was formed in 2011. In 2013, another all-ARMM cohort—Cohort 6—was formed.

Cohort 2, on the other hand, included Daram in Samar. Bringing down maternal and infant deaths in this island-municipality that is considered a GIDA proved difficult. Challenged by this, ZFF opted to form cohorts of GIDAs. Cohort 4 had GIDA villages while Cohort 5 municipalities, like Daram, were GIDAs. Both were formed in 2012. Cohort 7, another all-GIDA cohort, was formed in 2013.

So while the Foundation kept its Health Change Model as the overarching strategy for reforms, the distinctive features of ARMM and GIDAs led ZFF to fine-tune its strategy so that it remains useful, relevant and effective.

In building prototypes for poor, ARMM and GIDA municipalities, the Foundation picked up several learnings *(see "The Learnings" on page 10)* that strengthened its Health Change Model to such a degree that it could be replicated by other stakeholders.

EFFICIENT PROGRAM FOR REPLICATION

Before it could be scaled up or replicated, the Foundation worked on a program that would be more cost effective and efficient.

Since the early prototypes involved a two-year capacity-building program called the "Community Health Partnership Program" (CHPP) with grants to build and equip health facilities, ZFF created a shorter capability-program without the grants.

In partnership with the University of Makati (UMak), a certificate course on health leadership and governance program was introduced to Makati City's eight sister-municipalities in 2011.

Both the two-year and one-year courses followed the training-practicum pattern of building leaders' capacities.

The capacity-building is aimed at transforming health leadership and governance. This is seen as the first step toward achieving better health outcomes for the poor—improved leadership and governance means reduced health inequities. The "bridging leadership" framework *(see "The Bridging Leader" on this page)* is used to initiate the transformation.

During the practicum phase, trained health leaders apply what they have learned to make improvements in the building blocks of the health system as enumerated by the World Health Organization: leadership and governance, financing, workforce, information systems, medicines and technologies, and services.

All health leaders were closely monitored and mentored as they improved their local health systems.

The UMak certificate course was ZFF's prototype for the one-year, cost-efficient program being replicated now in more LGUs with the Department of Health.

At the end of 2014, there were 72 prototype municipalities, of which 51 have finished the formal partnership program and are now classified as "ZFF alumni." In general, significant improvements have been made in terms of reducing maternal deaths. Note, however, that an ongoing challenge for ZFF involves cases of Cohort 1 ARMM municipalities in Maguindanao, where maternal deaths rose in 2014, and the GIDA municipalities, where despite a decrease in MMR, the figure remained high in 2014. *(See charts on maternal mortality ratio on page 11)*

THE BRIDGING LEADER

A bridging leader is one whose values compel him/her to own and address societal inequities. This leader likewise convenes and engages other stakeholders toward a shared response to resolve issues and come up with new institutional arrangements to address the inequities.

THERE ARE THREE MAIN STEPS IN THE "BRIDGING LEADERSHIP" PROCESS. THESE ARE OWNERSHIP, CO-OWNERSHIP AND CO-CREATION.

Under **ownership**, a leader embraces one's responsibility over a social problem. This includes an understanding of the problem and accepts one's own role in the issue.

Understanding the complexities of the problem moves the leader to get relevant stakeholders involved in finding solutions. A bridging leader unifies individual stakeholder's beliefs, values, points of view and insights on the issue. To make this possible, it is important for the leader to hold dialogues with the people. Once differences have been settled, there can be a shared vision and joint response; hence, the problem is not just of the leader's but of the community's. This is **co-ownership.**

Addressing the problem requires strategies that call for new and innovative ways of doing things. A leader facilitates the creation of these new institutional arrangements, which ought to be inclusive and transparent such that they empower the people and make institutions more responsive. This is **co-creation.**

The bridging leadership approach was developed by the AIM-Mirant Center for Bridging Societal Divides (now the Team Energy Center for Bridging Leadership) as an offshoot of its collaboration with the Synergos Institute in New York City.

ZFF president, Ernesto Garilao, is the founding executive director of the AIM-Mirant Center for Bridging Societal Divides. He was part of the Synergos Institute global research initiative on bridging leadership. After this, he led a small team of AIM faculty and staff to develop and teach the bridging leadership approach.

Prototyping: **The Learnings**

The process of leadership transformation starts with self-awareness, an understanding of the social problem at hand and a personal commitment to improve the situation.

While the Foundation's training program helps mayors and other health leaders build their capacities in leadership and governance, it is what they do with their acquired skills and knowledge that will lead to better health outcomes.

ZFF's experiences with its prototype municipalities revealed the following factors that resulted in better health outcomes:

Presence of health leaders is very important. Not only do people appreciate seeing their health leaders with them, it is a major factor in finding out problems in the municipality.

Knowing the issues require having the right health information. All cases of pregnancies must be known to ensure proper pre-and-post natal care and to identify complicated cases. This is possible if **there is a pregnancy tracking system.** The use of available information and communications technology can make data gathering, recording and reporting more efficient and accurate.

Health boards at the municipal and barangay levels must be functional if health issues are to be tackled and solved immediately. Also, when representation to the health boards are expanded to include budget officers, social workers, police officers, and other socio-economic sectors, programs and reforms will more likely generate the needed popular support.

Health policies and programs must be backed by legislation to strengthen their implementation.

Health must be given sufficient budget allocation because programs without funding would be difficult to implement. Having enough funding will also enable municipalities to **keep and hire competent health personnel,** train them, and meet the ideal health worker to population ratio.

If internal revenue allotment (IRA), from where budgets are drawn is low, municipalities can get capitation from the **Philippine Health Insurance Corp., (PhilHealth)** provided their health facilities are PhilHealth-accredited.

PhilHealth accreditation requires meeting specific standards on the number of competent health workers, functional medical equipment and rooms, and availability of emergency medicines.

If municipalities' facilities are accredited, then the people, once enrolled in PhilHealth can be assured of getting quality healthcare services for free. While the national government has been enrolling the poorest of the poor, municipal governments can fund the enrollment of the poor who do not belong to quintiles 1 or 2. Some ZFF municipalities with 4-in-1 accreditation have more than enough funds for their present programs so their challenge is to come up with new and innovative health programs to further improve the health status of the poor.

Health facilities, aside from the Rural Health Unit (RHU), **must be available and easily accessible** to the people, especially those living far from the town center, where RHUs are usually located.

But are the people informed about all these programs, facilities and PhilHealth benefits? **Communicating** these **to the public is very important.** An informed community is an empowered community who will demand for its right to quality healthcare; and thus, make health reforms sustainable.

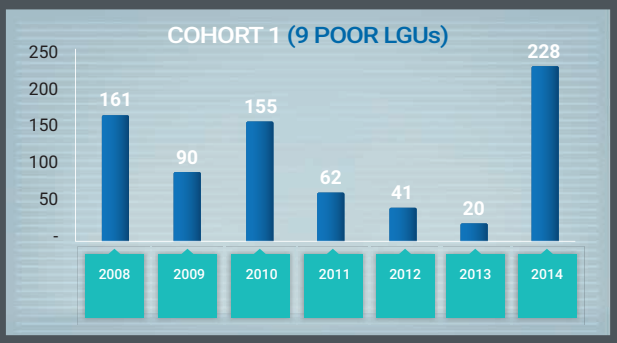
An informed community will avail of the services. This will lead to increases in skilled birth attended (SBA) deliveries as well as facility-based deliveries (FBD), which have been found effective in reducing maternal and infant deaths. Oftentimes, though, leaders will be faced with the challenge of **breaking unhealthy traditional practices.** To overcome these, it helps to get local religious and other influential leaders onboard health information drives. This was particularly effective in the Autonomous Region in Muslim Mindanao.

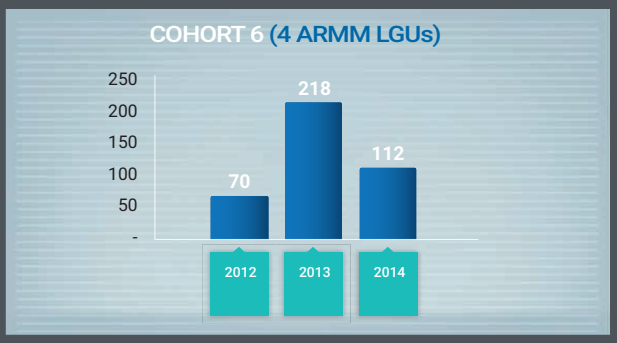
Then there are those residing in far-flung villages. They cannot easily be convinced to get regular checkups in the health centers because of the distance, difficulties and costs the travel would entail. For these cases, **municipal governments must offer incentives** that include monetary assistance, transportation facilities and even accommodation because for some patients—the mothers, in particular—being away from their homes means having no one to look after the rest of their children and/or having no one to care for them in the health facility. By having a place to stay near the health center, a mother's loved ones can accompany her. In a number of ZFF LGUs, maternal shelters were built near birthing centers.

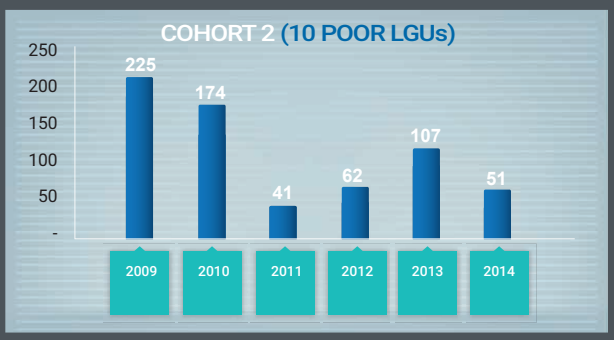
Some pregnancy cases, however, require health services that are beyond what primary care facilities in the municipalities can provide. When this happens, cases must be referred to hospitals; thus, **a properly functioning referral system** must be in place. This means the identified referral hospital is informed early on about the case. The mother is given enough resources to reach the hospital on time. Return referral must also be made, i.e., the RHUs must know what happened to the case referred.

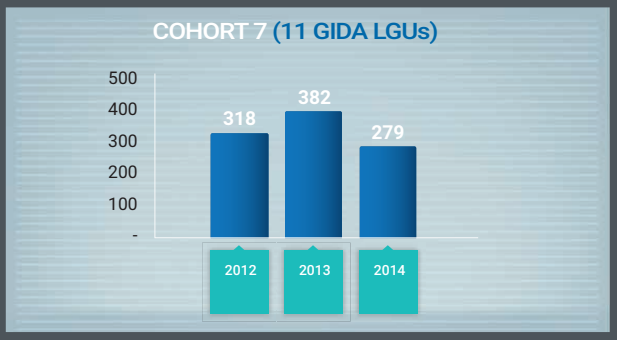
These measures have helped ZFF's partner-LGUs improve their health systems and indicators. However, the fact that deaths continue means there is still room for improvements and gaps that need to be filled. ZFF is continuing its search for effective solutions and innovations to health problems.

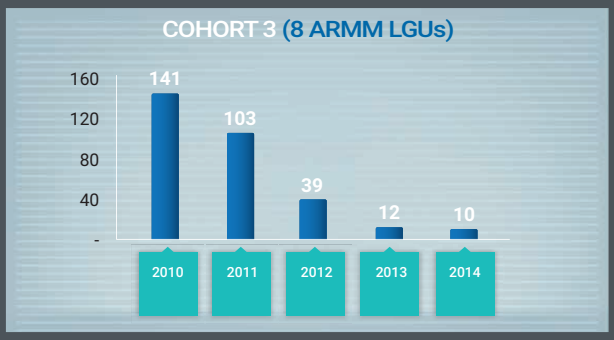
MATERNAL MORTALITY RATIOS OF ZFF'S PROTOTYPE MUNICIPALITIES*

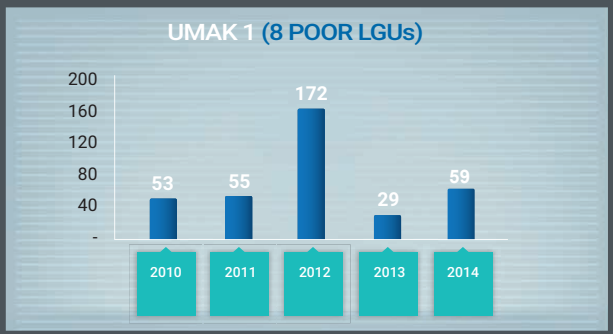


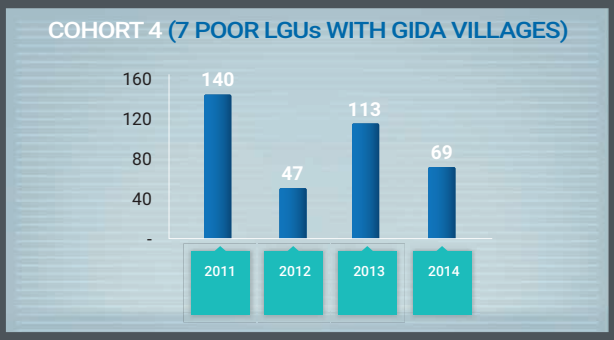


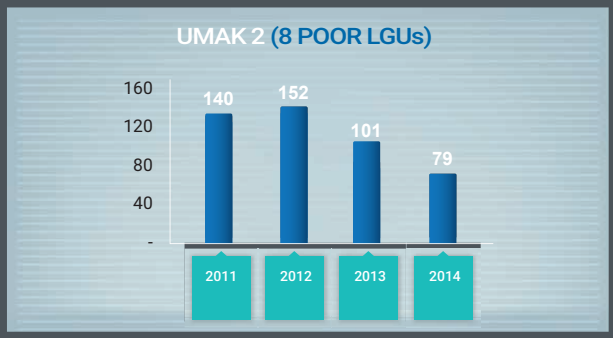


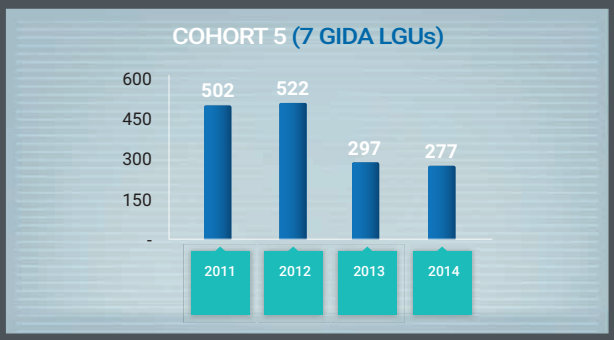












Maternal mortality ratio (MMR) in all prototype sets of municipalities, except Cohort 1 and UMak 1, declined in 2014. The increase in Cohort 1's MMR was due to 10 deaths, eight of which occurred in two Maguindanao municipalities. Overall live births of Cohort 1 also decreased, further causing MMR to increase. Aside from poverty and security issues, Maguindanao is faced with a number of health challenges: lack of skilled manpower with two municipalities sharing the same municipal health officer (MHO) and prevalence of the traditional health practice of giving birth at home. Also, for the most part of 2014, ZFF had no dedicated account officer to closely monitor the Maguindanao municipalities.

*Partial unofficial data
Sources: Municipal Field Health Services Information System

Limasawa, Southern Leyte

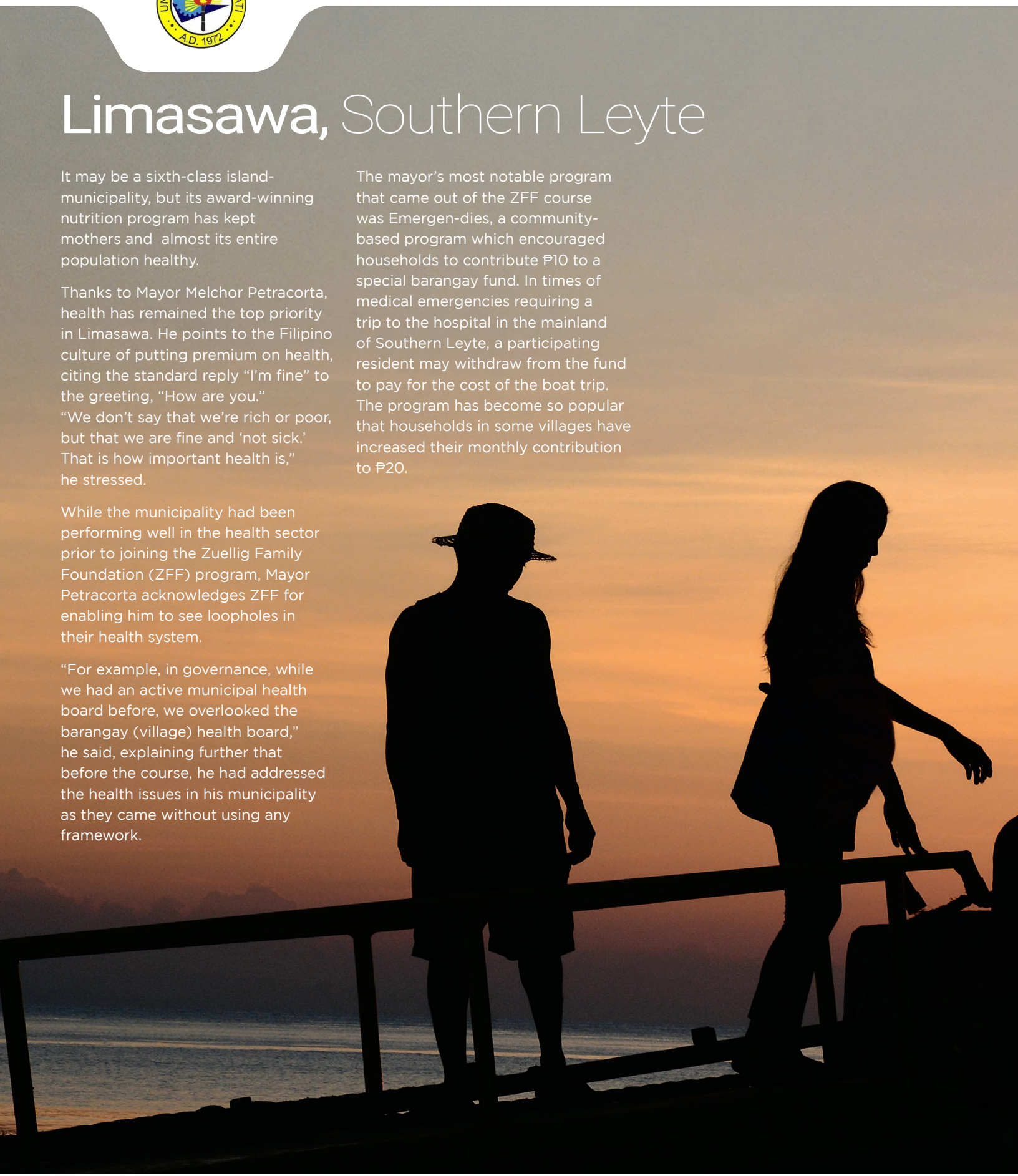
It may be a sixth-class island-municipality, but its award-winning nutrition program has kept mothers and almost its entire population healthy.

Thanks to Mayor Melchor Petracorta, health has remained the top priority in Limasawa. He points to the Filipino culture of putting premium on health, citing the standard reply "I'm fine" to the greeting, "How are you." "We don't say that we're rich or poor, but that we are fine and 'not sick.' That is how important health is," he stressed.

While the municipality had been performing well in the health sector prior to joining the Zuellig Family Foundation (ZFF) program, Mayor Petracorta acknowledges ZFF for enabling him to see loopholes in their health system.

"For example, in governance, while we had an active municipal health board before, we overlooked the barangay (village) health board," he said, explaining further that before the course, he had addressed the health issues in his municipality as they came without using any framework.

The mayor's most notable program that came out of the ZFF course was Emergen-dies, a community-based program which encouraged households to contribute ₱10 to a special barangay fund. In times of medical emergencies requiring a trip to the hospital in the mainland of Southern Leyte, a participating resident may withdraw from the fund to pay for the cost of the boat trip. The program has become so popular that households in some villages have increased their monthly contribution to ₱20.



Partner: UNIVERSITY OF MAKATI (UMAK)

- Forged in 2011, the program is for Makati City sister-local government units

Program: CERTIFICATE COURSE ON PUBLIC HEALTH GOVERNANCE

- Two-module, one-year course with practicum and coaching in-between modules
- Course was the prototype for the "Municipal Leadership and Governance Program" being replicated across the country

LIMASAWA, SOUTHERN LEYTE	2012	2013	2014
Maternal deaths	0	0	0
Infant deaths	0	0	0
Facility-based delivery (%)	99	100	99
Skilled birth attendant (%)	100	100	100

Source: Municipal Field Health Services Information System

MAP OF SOUTHERN LEYTE

Limasawa is an island-municipality located in the southern tip of Southern Leyte. About 37 kilometers south-east of the province's capital of Maasin, it is a sixth class municipality with a land area of 700 hectares. It is the site of the first Catholic mass in the country held on March 31, 1521.

Taraka, Lanao del Sur

A non-devolved health setup and a limited health budget do not prevent health leaders of Taraka in Lanao del Sur from giving their constituents quality healthcare.

"If there is a need to augment the budget, we find ways to do that. If we have spare budget, we allocate it to healthcare," said Mayor Nashiba Gandamra-Sumagayan.

A major challenge for Taraka was the lack of a functional Rural Health Unit (RHU), according to the mayor, who succeeded her husband Odin in 2013. It was during Mayor Odin's term that the municipality became part of Zuellig Family Foundation's partnership program in 2011. The year before that was the last time they reported a maternal death.

Now, Mayor Nashiba builds on what her husband started. While it is a reality that elected positions are usually passed on to family members, it is not just a matter of taking over a position for this family. It is about keeping the commitment to serve the public.

After ZFF trained the health leaders and helped in the renovation of the RHU, other reforms followed, according to Mayor Nashiba. They added health personnel, including a medical technologist and a dentist. They also acquired an ambulance and gave their health workers training programs.

Cascading their learnings to barangay health workers (BHWs) gave BHWs a better appreciation on the importance of their duties. Mayor Nashiba also directed barangays (villages) to allot funding for BHWs' salaries and incentives given their responsibilities, which include tracking and monitoring every pregnancy case.

Municipal health officer Bolawan Delawi, M.D. admits they still have cases of home deliveries despite an order banning it. But she hopes that with a maternal shelter now open, more mothers will choose facility-based delivery. All expectant mothers are also assured of free pre- and post-natal care and newborn screening.

Mayor Nashiba says that all their health programs are now in place. Dr. Delawi agrees that with their mayor's commitment, and with their health leadership team working as one, they have achieved their health goals. The mayor cautions though that the challenge remains in sustaining these gains.

Program: HEALTH LEADERS FOR THE POOR

- Under ZFF's Community Health Partnership Program
- Four-module, two-year capability-building program with practicum in-between modules and grants for health facilities and equipment

TARAKA, LANAO DEL SUR	2012	2013	2014
Maternal deaths	0	0	0
Infant deaths	0	0	2
Facility-based delivery (%)	52	77	85
Skilled birth attendant (%)	85	92	86

Source: Municipal Field Health Services Information System

MAP OF LANAO DEL SUR

Taraka is a fourth-class municipality in Lanao del Sur. It is 28 kilometers east of the province's capital of Marawi City and has a land area of 435 hectares. Majority of its people are from the ethnic group Maranao.

Matuguinao, Samar

Mayor Melissa Dela Cruz says mentioning geographically isolated and disadvantaged areas (GIDAs) brings to mind her town of Matuguinao, Samar.

For years, residents endured four to five hours of river travel just to reach the next town of Gandara. Thus, the mayor made it her priority to build a road to connect her town and make travel easier for her people.

A road now connects Matuguinao to Gandara and has cut travel time to an hour by motorcycle. But 17 of its 20 villages remain accessible only by foot. In some of these far-flung villages, security is also a serious concern as clashes between the army and the New People's Army have erupted in these areas. Most of its villages are still without electricity and mobile phone signal is poor, making internet access almost impossible.

Despite these difficulties, Mayor Dela Cruz forges on. If there is one thing the Zuellig Family Foundation program has taught her, it is to take full ownership of her people's health.

She used to dismiss maternal death as a normal consequence of not listening to health advice. But now, she knows she must exert more effort for these mothers. "I know 100 percent FBD (facility-based delivery) is a distant dream given our town's present condition, so we continue to think about means and ways to get more mothers to choose FBD."

Partner: MERCK SHARP & DOHME (MSD)

- Forged in 2013, the partnership is under the pharmaceutical company's **"MSD for Mothers,"** a global program aimed at reducing maternal deaths
- Partnership program is focused on improving maternal health among poor mothers in the geographically isolated and disadvantaged areas in Samar and Northern Samar provinces

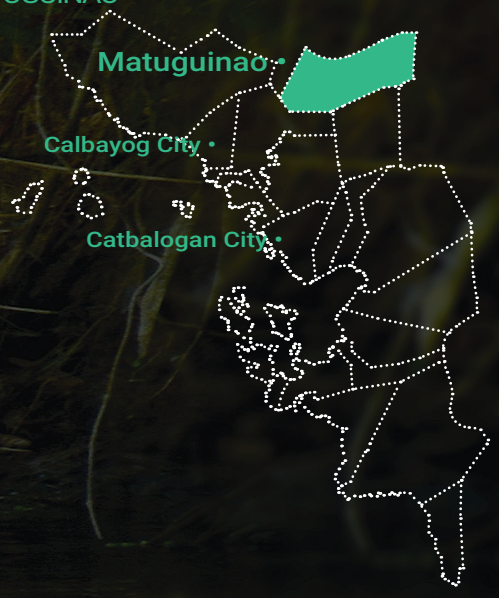
Program: HEALTH LEADERS FOR THE POOR

- Two-year, four-module capacity-building program with practicum and coaching in-between modules and grants for health facilities and equipment

MATUGUINAO, SAMAR	2012	2013	2014
Maternal deaths	1	1	0
Infant deaths	9	5	7
Facility-based delivery (%)	38	41	67
Skilled birth attendant (%)	42	43	67

Source: Municipal Field Health Services Information System

MAP OF MATUGUINAO



Matuguinao is a fifth-class upland municipality 41 kilometers from the provincial capital of Catbalogan City and 32 kilometers from Calbayog City, where the referral hospital is located. Occupying an area of 17,250 hectares, its total population is 6,746.

Attaining **better health outcomes** is our **bottom line**

Health leaders need to embrace their responsibility for their constituents' health. They need to listen to their people's voices and aspirations and reconcile their differences. Leaders must be able to bring their people to work together toward a common health vision.

"ZFF's undertaking is not about racing to have the most number of partner-LGUs, but about a race to allow the poor to lead healthier lives."

The goal that has always resonated since Zuellig Family Foundation (ZFF) began implementing its strategy is to achieve better health outcomes for the rural poor.

This is the reason why the Foundation focused on rural areas. It is the rural poor who face great health inequities. This is also the reason it accepted the challenge of getting into geographically isolated and disadvantaged areas (GIDAs). Physically getting there was already a challenge. Once there, the Foundation found that issues beyond health had plagued the municipalities. There was insurgency, high illiteracy rate and lack of livelihood. All these contributed to the people's traditional and poor health-seeking behavior.

Take the case of Matuguinao, Samar. This town is considered a GIDA. A road connecting it to the next town was only built in 2014 *(see related story on page 16)*. Here, the Foundation first met Aiza dela Cruz last September, when she was heavy with her second child.

PREGNANCY IN HARD-TO-REACH AREAS

She, along with her husband and daughter, agreed to make a video to dramatize the difficulties a pregnant woman living in a GIDA goes through to get medical care. A few days after making the video, Aiza suffered from high blood pressure and a leaking bag of water. She was immediately referred to the Calbayog City hospital and given financial aid by the Matuguinao government. She delivered her baby boy safely on September 23. Aiza can be considered luckier than other women in her town. While no stranger to taking long hikes, crossing rivers, and scaling inclines when visiting other villages, Aiza lives in the poblacion (center),

Nine months pregnant with her second child, Aiza Dela Cruz of Matuguinao, Samar is shown here with husband Bayani and daughter Rezalyn. She would later be referred to a hospital in Calbayog City when she developed complications. To make sure she gets to the hospital on time, the local health leadership, headed by the mayor of Matuguinao, gave her financial support.

where access to the Rural Health Unit (RHU) is much easier than to those living in other villages that can only be reached on foot. Yet there are no footpaths and bridges connecting most of these villages to the center.

She is also fortunate because during her second pregnancy, the Matuguinao health leadership had already put in place policies and programs to ensure women safely deliver their babies.

The local government unit (LGU) has a pregnancy tracking system to monitor every pregnant woman. Gatherings of pregnant women are being held to inform women and their spouses about proper natal care. A referral system is also in place so that women needing hospital care, like Aiza, can immediately proceed there and receive proper care. With *habal-habal* (motorcycle) drivers mobilized for health emergency cases and financial aid provided, pregnant mothers will likely not be late in reaching the referral hospital.

For some Matuguinao mothers, however, the difficult travel is a deterrent to having themselves and their children regularly checked. It is not uncommon therefore, to see health workers making, precarious three- to-nine hour, one-way foot travel to bring health services to villages located 7 to 26 kilometers from the town center.

Now, Aiza's focus is on making sure her children remain healthy, bringing kids Rezalyn, 3, and baby RJ to the RHU for their scheduled immunization

MATERNAL DEATHS

	2012	2013	2014
Cohort 1	2	1	10
Cohort 2	4	7	3
Cohort 3	3	1	1
Cohort 4	3	7	4
Cohort 5	10	6	5
Cohort 6	1	3	2
Cohort 7	12	15	12
UMak1	6	1	2
UMak2	8	5	4
Total	**49**	**46**	**43**

INFANT DEATHS

	2012	2013	2014
Cohort 1	13	21	18
Cohort 2	54	41	44
Cohort 3	15	6	17
Cohort 4	46	34	19
Cohort 5	49	31	33
Cohort 6	10	18	11
Cohort 7	56	68	46
UMak1	32	5	21
UMak2	37	16	34
Total	**312**	**240**	**243**

FACILITY-BASED DELIVERY (%)

	2012	2013	2014
Cohort 1	53	64	60
Cohort 2	85	89	87
Cohort 3	30	40	54
Cohort 4	56	59	80
Cohort 5	35	52	67
Cohort 6	11	26	43
Cohort 7	37	69	74
UMak1	88	65	90
UMak2	62	69	72
Total	**55**	**62**	**70**

SKILLED BIRTH ATTENDANT (%)

	2012	2013	2014
Cohort 1	69	76	75
Cohort 2	87	89	89
Cohort 3	72	73	78
Cohort 4	58	76	80
Cohort 5	54	64	77
Cohort 6	49	53	65
Cohort 7	60	73	75
UMak1	84	65	90
UMak2	71	73	76
Total	**70**	**75**	**79**

Overall, improvements in maternal and child health indicators occurred in ZFF's prototype municipalities. There was, however, a significant increase in the maternal deaths in Cohort 1. Four of the deaths occurred following home deliveries. The six other cases have yet to be reviewed to pinpoint the cause and place of death. Eight of the deaths in this cohort occurred in two Maguindanao municipalities.

*Partial unofficial data
Sources: Municipal Field Health Services Information System

and vitamin supplementation. She is in no rush to have another child. Under the care of Matuguinao health workers, she will have access to family planning services.

PARTNERSHIPS TO INFLUENCE MORE HEALTH LEADERS

Matuguinao's programs and other health system reforms are the outputs the Foundation wants to see from its partner-LGUs so that better health outcomes can be achieved. It is among ZFF's 72 cohort-municipalities that have shown significant health improvements despite the odds that they face.

The LGUs' performance has inspired the Foundation to seek partnerships that would allow more LGUs to benefit from its strategy. ZFF has forged partnerships with Merck Sharp & Dohme (MSD), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and United States Agency for International Development (USAID).

These program partnerships enabled ZFF to reach more municipalities it would otherwise not be able to because of resource constraints. Then, the partnership with the Department of Health was realized in May 2013 and it involves reaching 609 priority LGUs.

But ZFF's undertaking is not about racing to have the most number of partner-LGUs, but allowing the poor to lead healthier lives.

The Foundation measures its success not in the number of health leaders it has trained, nor in the health facilities that it funded. Rather, it looks at improvements in the municipal, provincial, and regional health indicators, particularly maternal mortality, to see if it has made a difference—a health impact.

LEADERS' IMPACT ON MAKING THE POOR HEALTHY

It is ambitious, but the Foundation does not think it is impossible to accelerate the decline in preventable maternal deaths if local health leaders act on the health situation in their respective areas.

If a town like Matuguinao—poor, geographically isolated and faced with security threats—could implement health programs and improve health indicators with minimal resources, then there is no excuse for other LGUs not to do the same.

ZFF has brought major stakeholders—the DOH, MSD, UNFPA, USAID, UNICEF—to help poor LGUs improve their health systems. ZFF's and their combined resources have introduced reforms aimed at improving the health of the poor, but the real health impact will only be realized if health leaders act on the health challenges that prevent their people from receiving timely, high-quality and affordable healthcare.

Health leaders need to embrace their responsibility for their constituents' health. They need to be able to listen to their people's voices and reconcile their differences. Leaders must be able to bring their people to work together toward a common health vision. While these may be easier said, they can be done. ZFF's municipalities finished with the ZFF program can prove this with what they have accomplished in their health systems.

After giving birth to RJ, Aiza continues to regularly visit the Matuguinao Rural Health Unit to get herself and her children checked.

Partnership: Creating added value, innovating and reaching more areas

A pregnant mother and her son cross the lone bridge that connects their mining community in New Bataan, Compostela Valley to the main road of their village. This municipality's health system was functioning well until typhoon Pablo ravaged the town in 2012 and killed hundreds of residents. The struggle to recover from the tragedy continues.

Forging partnerships with different organizations enabled the Zuellig Family Foundation (ZFF) to expand to hundreds of other rural municipalities like New Bataan. Having partners that share ZFF's vision of attaining better health outcomes for the poor has led to strengthened program interventions and innovations. With partners, ZFF has introduced programs for improving reproductive health, increasing access to family planning services, and developing resilient health systems.

Motivated by the health improvements in its prototype municipalities, the Foundation crafted a 10-year plan in 2012 with the intention of reaching 485 municipalities.

As ZFF and its partners pursue the vision of achieving better health outcomes for the poor, the Foundation also continues to seek more stakeholders with a similar vision, because there are still more areas to cover and a lot that can be done to improve the health of poor Filipinos.

Such target could potentially help bring the country's maternal mortality ratio down to the targeted 52.

While ZFF was prepared to allot P100 million annually for the plan, it knew this was not enough to achieve its goals. So leveraging the health success its partner-municipalities had achieved, the Foundation began seeking partners who found congruence between ZFF's Health Change Model and their own strategy and programs.

The first to respond was the United Nations Population Fund. Their programs put emphasis on maternal and reproductive health. Along with their technical expertise, ZFF's leadership and governance interventions were given to the health leaders of UNFPA's nine identified provinces of Ifugao, Mountain Province, Albay, Camarines Norte, Eastern Samar, Sarangani, Sultan Kudarat, Compostela Valley and Surigao del Sur. *(See health indicators on page 25.)*

The five-year partnership program began in late 2012, when governors and their provincial health teams underwent leadership and governance training. In the second half of 2013, mayors and municipal health officers (MHOs) of selected municipalities in the nine provinces started receiving capacity-building programs.

Global pharmaceutical company Merck Sharp & Dohme (MSD) was the next to partner with the Foundation. Through the "MSD for Mothers" worldwide campaign of the company, a partnership program was created targeting poor pregnant women in 20 geographically isolated and disadvantaged areas (GIDAs) of Samar and Northern Samar.

These GIDAs were grouped into cohorts that are under the prototyping initiatives of the Foundation. Unlike health leaders of the UNFPA municipalities, who undergo a one-year capacity-building program, those under the MSD partnership undergo two years of training and coaching.

Next partnership was with the United States Agency for International Development (USAID). Along with maternal and child health, tuberculosis is another focus of the partnership program forged with USAID. Targeting 121 local government units, including 37 in the Autonomous Region in Muslim Mindanao, this three-year partnership that started in October 2013 began engaging seven provinces last 2014: Batangas, Iloilo, Misamis Oriental, Zamboanga del Norte, Zamboanga del Sur, Zamboanga Sibugay and Tawi-Tawi.

A couple belonging to the Mandaya ethnic group in Compostela Valley bring their newborn to the New Bataan Rural Health Unit for a checkup.

MATERNAL & INFANT HEALTH STATISTICS IN 9 UNFPA-ZFF PROVINCES*

Provinces	Infant deaths			Maternal deaths		
	2012	2013	2014	2012	2013	2014
Ifugao	37	41	24	1	2	0
Mt. Province	41	37	71	3	2	2
Albay	180	149	46	18	9	12
Camarines Norte	179	145	211	6	29	27
Eastern Samar	86	54	35	14	9	8
Sarangani	36	31	46	13	9	7
Sultan Kudarat	153	121	99	26	13	12
Compostela Valley	91	96	34	11	29	21
Surigao del Sur	82	64	86	6	16	17
Total	**885**	**738**	**652**	**98**	**118**	**106**
	8.5	*7.2*	*6.1*	*93.9*	*115.4*	*99.9*
		IMR			***MMR***	

Most maternal deaths in Surigao del Sur and Albay occurred in hospitals. Delay in seeking medical care on the part of mothers factored in the deaths, along with the inadequate number of specialists in the hospitals. In Albay, most of the deaths were due to eclampsia.

*2013 and 2014 figures are partial unofficial
IMR: Infant mortality rate = infant deaths / live births x 1,000
MMR: Maternal mortality ratio = maternal deaths / live births x 100,000
Sources: Regional and provincial Field Health Services Information System

PARTNERING TO ACHIEVE INTEGRATED DEVELOPMENT OF COMMUNITIES

The United Nations Children's Fund (UNICEF) partnership will run between February 2014 and April 2016. Since the program included six cities, a program tailored for cities was crafted with the help of the Department of Health. This program, the "City Leadership and Governance Program," is also being given to the three USAID cities of Batangas, Iloilo and Cagayan de Oro.

Also with the UNICEF, the Foundation has been helping 12 Eastern Samar and Samar municipalities affected by super typhoon Haiyan (local name: Yolanda) develop resilient health systems. This follows ZFF's "Recovery Assistance Program for Mothers" given to the same 12 local government units to ensure pregnant and lactating women continue to get proper post-disaster natal care. *(See pages 28-29 for related information.)*

These partnerships have allowed the Foundation to reach a scale it could not have otherwise achieved alone.

As ZFF and its partners pursue the vision of achieving better health outcomes for the rural poor, the Foundation also continues to seek more partners with a similar vision because there are still more areas to cover and a lot that can be done to improve the health of poor Filipinos.

New Bataan, Compostela Valley

In December 2012, typhoon Pablo ravaged the municipality of New Bataan in Compostela Valley, stunting whatever advances local officials have made on health.

The municipality's health infrastructure and human resources suffered. Among the hundreds who died was a midwife. Three barangay health stations were totally damaged.

"One of our greatest challenges was how to deliver health services to all of New Bataan's constituents after the typhoon," municipal health officer (MHO) Aurea Suarez-Solilap, M.D. said.

The recovery was made possible by the good relations between the MHO and Mayor Lorenzo Balbin, Jr. Both were also introduced to the Foundation's Municipal Health Leadership and Governance Program in late 2013. From the program, the Mayor strengthened barangay (village) health leadership and ordered the creation of Barangay Health Boards with health budgets. Barangay health workers and midwives were given training and an increase in compensation.

These have led to improvements in facility-based delivery (FBD), skilled birth attendant (SBA) and quality pre-natal care. Yet ironically, maternal and infant death cases increased in 2014.

Against medical advice, a mother went home after delivering her baby because no one was home to care for the rest of her children. Another gave birth at home because the traditional birth attendant was a good friend whom she trusted. Due to religious beliefs, another mother suffering from hemorrhage refused blood transfusion. All three died.

New Bataan leaders acknowledge that they continue to struggle in restoring their health system after typhoon Pablo's destruction. And with populations steeped in traditional beliefs and practices, innovations are needed to arrive at mutually acceptable health programs for mothers and children.

Partner: UNITED NATIONS POPULATION FUND

- Forged in 2012, the five-year partnership covers 9 UNFPA provinces and selected municipalities in these provinces and is aimed at improving maternal and child health and reproductive health

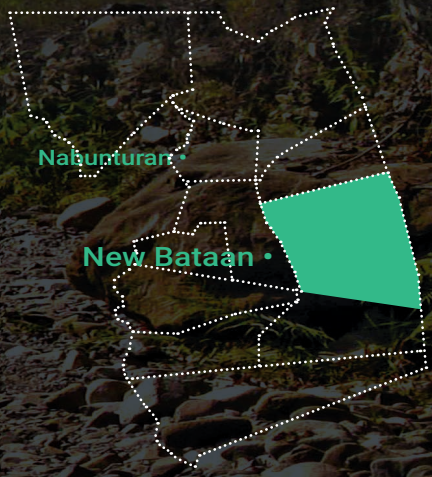
Program: MUNICIPAL LEADERSHIP AND GOVERNANCE PROGRAM

- Rollout of program for municipalities began in 2013, following the program for provinces
- One-year, two-module program given by Academic Partners and with coaching done by DOH representatives in-between modules

NEW BATAAN, COMPOSTELA VALLEY	2012	2013	2014
Maternal deaths	1	1	3
Infant deaths	0	3	11
Facility-based delivery (%)	65	70	87
Skilled birth attendant (%)	70	72	90

Source: Municipal Field Health Services Information System

MAP OF COMPOSTELA VALLEY



Located 40 kilometers from the province's capital of Nabunturan, New Bataan was once known as "Cabinuangan" due to the tall trees called "Binuang" that grew in the area. Growth of the logging industry led people to settle in the area. Classified as a first class municipality, New Bataan was hard hit by typhoon "Pablo" that left hundreds dead.

Recovery to **resiliency**

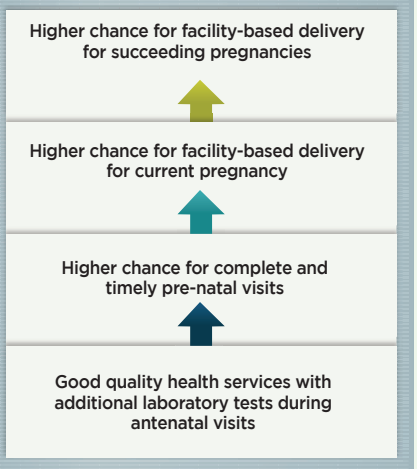
Health issues following disasters can linger, like in the case of New Bataan municipality (see page 26), unless health systems are strengthened. And this involves responsive leadership and different stakeholders working together.

In the case of super typhoon Haiyan (local name: Yolanda) in November 2013, the Foundation, with funds from the US-Philippines Society introduced the limited-term "Recovery Assistance Program for Mothers" (RAP) in 12 Eastern Samar and Samar municipalities. Targeting the vulnerable populations of women and children, RAP ended in July 2014. It benefitted 4,253 pregnant and lactating women *(see table below)* and resulted in FBD and SBA reaching beyond the 85% national target. No official maternal death was also reported during the period. A subsequent study on the program showed that the program was perceived to be effective in capturing vulnerable groups and increasing the uptake of maternal health services.

Following RAP, the Foundation moved to helping the 12 municipalities develop resilient health systems. Health leaders must prepare for worst-case scenarios given the country's vulnerability to natural disasters. By having a resilient health system, delivery of basic health services are uninterrupted before, during and after disasters.

Done in partnership with the United Nations Children's Fund, the program has the end view of creating a system that minimizes health risks, protects vulnerable populations—the women and children—and reduces inequities during post-disasters.

BETTER SERVICES = HIGHER FBD



Source: Valera, M. & Silfverberg. (2014). "Rapid Assessment of Factors Influencing Access to Maternal Healthcare Services in ZFF Recovery Assistance Program Areas"

NUMBER OF BENEFICIARIES AND AMOUNT DISBURSED

Municipality	Total No. of Identified Mothers by the Health Centers *(January 2014)*	No. of Mothers who Received RAP Incentives *(July 2014)*	Total Amount of Incentives Disbursed to Pregnant and Lactating Women
Basey	688	952	1,266,800.00
Marabut	305	356	432,450.00
Balangiga	216	250	310,750.00
Balangkayan	161	219	215,600.00
Gen. MacArthur	254	269	339,900.00
Giporlos	187	221	252,400.00
Guiuan	267	752	861,750.00
Hernani	83	150	173,100.00
Lawaan	190	237	291,800.00
Mercedes	92	127	156,900.00
Quinapondan	242	269	321,700.00
Salcedo	233	451	490,500.00
TOTAL	**2,918**	**4,253**	**Php 5,113,650.00**
			$116,219.32

Source: Master List of Mothers who Received Incentives (January-July 2014) from CARD, Inc. and Center for Community Transformation, Inc. (1 US$ = Php 44.00)

A FRESH START

Zuellig Family Foundation (ZFF) first met 29-year-old Tricia Joy Gacho a couple of weeks after she had lost her house and all belongings in the destruction wrought by typhoon Yolanda (Haiyan) on the coastal village of Maslog in Lawaan, Eastern Samar.

Four months pregnant when the super storm struck on November 8, 2013, Tricia welcomed the opportunity to be a beneficiary of ZFF's "Recovery Assistance Program for Mothers." RAP provided her with much-needed support in the form of a maternal kit and financial incentives to continue her pre-natal checkup.

In March 2014, Tricia safely delivered her fourth child, Jonathan. She gave birth with the help of Erlinda Antoc, the midwife of the clinic in the village of Bulusaw, where Tricia and her family have been resettled.

unicef

Puerto Princesa, Palawan

Despite a bustling tourism industry and its status as an urbanized first class city, almost half of Puerto Princesa City's 66 barangays remain rural. Its huge land area covering 2,540 square kilometers also makes access to healthcare services difficult for some. It takes about two hours from the city center to get to the farthest barangay (village).

One need not go far from the city center to see the disparity. Rows of makeshift houses made of light materials lie along the city's coastline, while just across the road reside the well-to-do in their concrete luxurious mansions.

Dr. Ricardo "Doc Ric" Panganiban knows this reality all too well. He spent the last 20 years serving as doctor assigned to far-flung areas before assuming the role of city health officer in November last year.

To address health issues, the city government clustered barangays and built satellite health centers with birthing facilities that are open 24/7.

RENEWED FOCUS ON HEALTH

It was not until Puerto Princesa became part of the UNICEF-Zuellig Family Foundation partnership's City Leadership and Governance Program last November that its health program gained a renewed sense of focus.

"We realized during the training that we should go to barangays that needed us the most. We did not prioritize some barangays (villages) and just gave resources to those who came to us," said Doc Ric.

In response to this realization, the city government identified the three poorest barangays and began working towards providing them with basic services like access to potable water.

To his credit, Doc Ric said Puerto Princesa Mayor Lucilo Bayron has been very supportive, adding that the mayor would often check on the status of health projects and would urge the Sangguniang Bayan to immediately pass ordinances to aid the city's health programs.

"Governance is at its best when the power of the governed is recognized and their needs are served efficiently and expediently," Mayor Bayron said.

A threat of recall election against Mayor Bayron does not worry city councilor Roy Gregorio Ventura, chair of the city's Committee on Health and Sanitation.

"We will continue to provide services. Only the local chief executive may be affected. There are department heads who are not involved in politics. There's time for politics, there's time for work," he explained.

Partner: UNITED NATIONS CHILDREN'S FUND

› Forged in 2013, the partnership covers 30 municipalities and 6 cities. It is aimed at improving maternal and child health.

Program: CITY LEADERSHIP AND GOVERNANCE PROGRAM

› One-and-a half-year program composed of three training modules with practicum periods in between

PUERTO PRINCESA, PALAWAN	2012	2013	2014
Maternal deaths	6	5	5
Infant deaths	52	46	57
Facility-based delivery (%)	74	79	84
Skilled birth attendant (%)	81	83	86

Source: City Field Health Services Information System

MAP OF PUERTO PRINCESA

Puerto Princesa became a city in 1970. It has a total land area of 253,982 hectares made up of 35 urban barangays and 31 rural barangays. It is 306 nautical miles southwest of Manila. South China Sea is on its west and Sulu Sea on its east.

USAID
FROM THE AMERICAN PEOPLE

Tawi-Tawi

Tawi-Tawi's health system is non-devolved and relies largely on the Autonomous Region in Muslim Mindanao Department of Health based in Cotabato City. This meant that local government units (LGUs) had little participation in the delivery of healthcare services in their municipalities.

Tawi-Tawi Governor Nurbert Sahali knows this situation very well. He was a three-term mayor of Panglima Sugala, one of Tawi-Tawi's 11 LGUs.

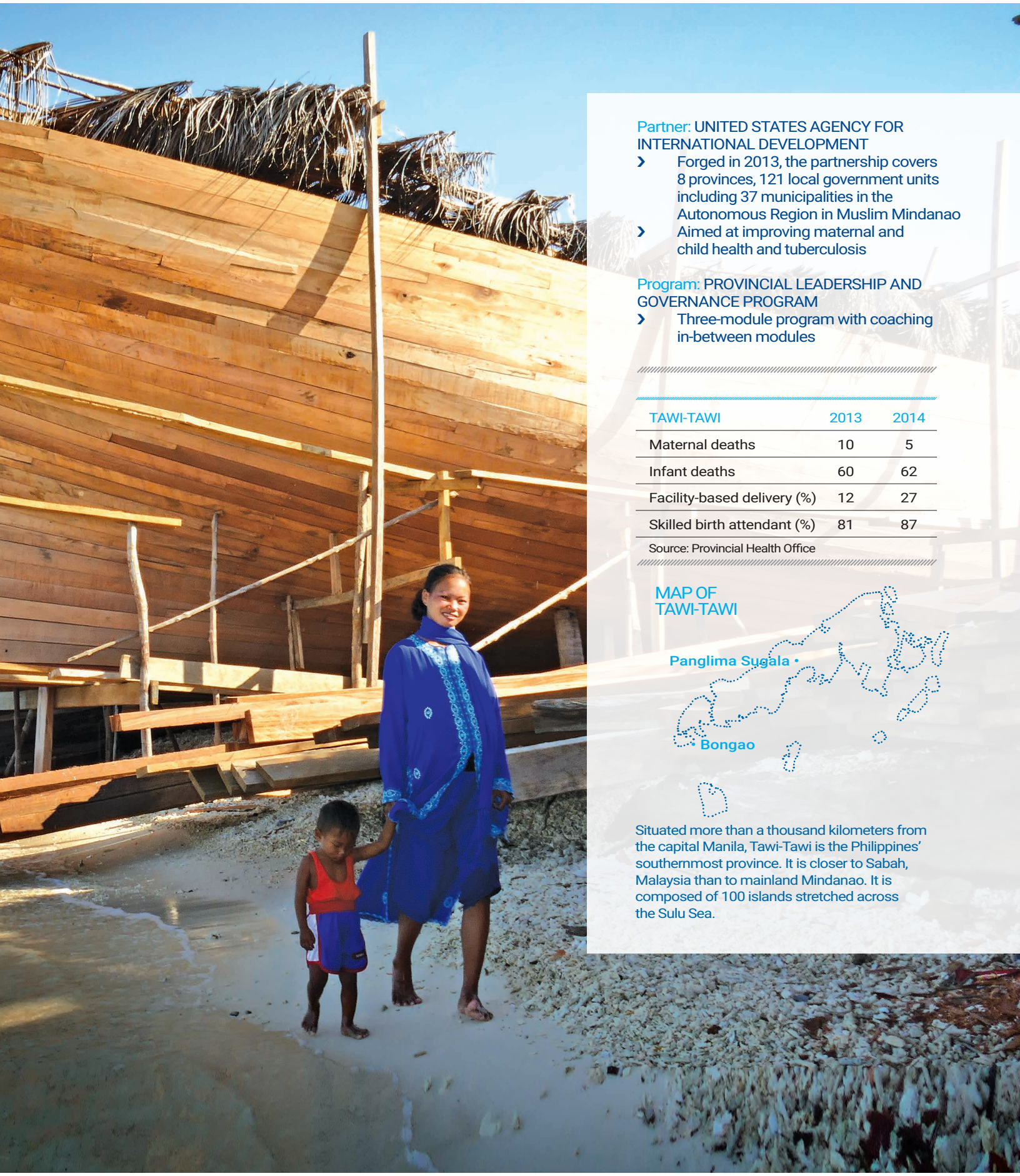
In 2011, then-Mayor Sahali was invited to join Zuellig Family Foundation's two-year Community Health Partnership Program (CHPP). The training was an eye-opener for Governor Sahali. "Before, I really had no idea on the health issues in our municipality. Now, my health advocacy is stronger and deeper."

When he became governor, health remained a top concern.

To improve its services, the provincial government gave funds to the hospital to hire more personnel.

Sahali also convinced other mayors to put health on top of their agenda. "First thing we did was to secure the commitment of the mayors. When I see some of them, I see my old self – no knowledge or idea about my role as chief executive on health issues in the community."

"Now, it is heartwarming to see mayors fully aware of the reports prepared by their doctors. I'm happy they know the health issues in their municipalities," he remarked.



Partner: UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

- Forged in 2013, the partnership covers 8 provinces, 121 local government units including 37 municipalities in the Autonomous Region in Muslim Mindanao
- Aimed at improving maternal and child health and tuberculosis

Program: PROVINCIAL LEADERSHIP AND GOVERNANCE PROGRAM

- Three-module program with coaching in-between modules

TAWI-TAWI	2013	2014
Maternal deaths	10	5
Infant deaths	60	62
Facility-based delivery (%)	12	27
Skilled birth attendant (%)	81	87

Source: Provincial Health Office

MAP OF TAWI-TAWI

Situated more than a thousand kilometers from the capital Manila, Tawi-Tawi is the Philippines' southernmost province. It is closer to Sabah, Malaysia than to mainland Mindanao. It is composed of 100 islands stretched across the Sulu Sea.

On the way to influencing the national impact

Muslims and Christians live peacefully together in Panglima Sugala, Tawi-Tawi. In this photo is veteran public health nurse Fatima Jahama as she chats with Lygen Cagang, a Christian, who came to the Rural Health Unit for her six-month-old daughter's regular checkup.

Since showing effectiveness in bringing down maternal mortality, the Zuellig Family Foundation has been hoping its strategy, the Health Change Model, could be replicated to create a wider impact on the health of Filipinos living in different parts of the country.

Its partnership with the Department of Health brings leadership and governance into the mainstream of the public health system. And this has led to the start of health system reforms and improved health indicators across the country.

When replicated or mainstreamed by other institutions, the Foundation's Health Change Model can have an impact on the nation's health.

Specifically, the Foundation was looking at the country's lead agency in health, the Department of Health (DOH), to mainstream the Health Change Model (HCM).

The Foundation saw an alignment of its strategy to the government's Kalusugang Pangkalahatan (Universal Health Care – UHC) agenda, which also aims to address inequities in the health system. The UHC has three strategic thrusts: expanded enrollment and benefits of the Philippine Health Insurance Corp. (PhilHealth); improved access to quality healthcare facilities; and the attainment of the Millennium Development Goal (MDG) health targets.

What ZFF has been doing through its leadership and governance capability-building program, with practicum in-between training modules, is enabling health leaders make the necessary reforms in the building blocks of their local health systems, such that services become more accessible and affordable, and their health indicators improve. Essentially, these are the same major thrusts of the government.

Recognizing the potential and relevance of ZFF's change strategy to its UHC, the DOH formalized a partnership with the Foundation in May 2013. This joint initiative is called the "Health Leadership and Governance Program" (HLGP), and is a three-year program involving 609 priority local government units (LGUs) identified by the National Anti-Poverty Commission (NAPC).

According to partnership program management committee chair Dr. Nestor Santiago Jr., who concurrently leads the DOH Regional Office IV-A (CaLaBaRZon), the partnership's impacts on the ground can be maximized to contribute to the achievement of the country's MDGs. "The HLGP aims to empower provincial and municipal leaders such that they are able to transform their local health systems and make health programs and services work for the community, especially the poor," Santiago explained.

For the Foundation, this partnership is the vital step toward the national health impact it wanted to achieve.

OTHER KEY REPLICATION PLAYERS

Aside from the DOH and ZFF, other stakeholders in the HLGP are academic institutions, PhilHealth, the League of Provinces of the Philippines, and the League of Municipalities of the Philippines.

Academic institutions or the academic partners (APs) are tasked to give the leadership and governance training to the mayors and municipal health officers (MHOs). Given the number of LGUs involved, it would have been impossible for the Foundation to carry out the training of all selected health leaders.

Eventually, these APs must make the leadership and governance program a regular course offering in their institutions. By making the course available and accessible to more interested leaders, the strategy of transforming leadership and governance is replicated.

At the end of 2014, ZFF had 10 academic partners: Ateneo de Zamboanga University, Benguet State University, Bicol State University, Cebu Normal University, Davao Medical School Foundation, Development Academy of the Philippines, University of the Philippines (UP) Visayas, UP Manila, UP Palo, and Xavier University.

Another responsibility of ZFF that had to be taken on, this time by the DOH, is the coaching of the municipal health leaders. This is now done by the DOH Development Management Officers (DMOs), who must also undergo the Foundation's "Health Leadership and Management Program" so they could be effective coaches.

POST HEALTH DEVOLUTION: NEED FOR LEADERSHIP AND GOVERNANCE STRENGTHENING

ZFF's strategy of focusing on local health leadership is needed given the health setup in the country. According to Dr. Santiago, health has been devolved to the local governments and local chief executives (LCEs) have the authority, accountability and resources to pursue local health system development.

"A governor or mayor can be transformed into a health champion—one who fixes the system, and makes health programs accessible to the poor and responsive to their needs," the director stressed, adding that the HLGP provides the institutional mechanism to engage the LCEs.

Before the ZFF's replication program, DOH staff experienced difficulties in advocating the agency's health programs to the mayors. "When we tried to convince the LCEs to implement the DOH's programs in their municipalities, they would say that

they did support us, but the budget they allotted for health would show otherwise," Dr. Gloria Balboa, Director of DOH Regional Office V (Bicol), said. The LCEs usually prioritized infrastructure projects such as roads and buildings, which are more tangible than "soft" projects such as health initiatives.

And while health leadership and governance is considered an important building block of the health system, "information about this concept and strategies to strengthen leadership and governance were only mentioned in passing during orientation programs," according to Dr. Regina Sobrepeña, DOH manager of the Bureau of Local Health Systems Development.

The devolution of certain functions such as health services to the LGUs, as specified in the Local Government Code of 1991, made it difficult for DOH staff to go down to the municipalities and the barangays. In contrast to the pre-devolution scenario when the DOH could easily disseminate its programs to the grassroots, local autonomy made it difficult for them to do so, as the LCEs would only prioritize the programs that they felt were important to them.

Dr. Myrna Cabotaje, Director of DOH Regional Office I (Ilocos), added that the DOH had previously focused on service delivery instead of implementing programs such as the HLGP.
"We were used to the hierarchical way of doing things: if the agency gives us an instruction and a target, the regional director would pass these down to the regional office and the local health officers for implementation,"Cabotaje shared.

Since the implementation of the DOH-ZFF partnership, the DOH officials have seen significant changes in the LCEs with respect to health priorities.

"The partnership is showing such encouraging results. Hopefully, these changes will be sustained and the LCEs will be able to operate and incorporate leadership and governance in the technical aspects of their programs and systems," Dr. Nimfa Torrizo of DOH Regional Office IX (Zamboanga) said.

Maternal health indicators in HLGP municipalities

Based on available information, regions have indeed been showing improvements *(see tables on pages 40-41)*. However, more complete and updated data could have given the Foundation, as well as health leaders, a better picture of the health situation in the different areas. While the DOH has handed down an order effectively speeding up the reporting of latest health indicators in the regional offices, the use of modern information and communications technology, like the Wireless Access for Health, could also greatly improve data gathering, reporting and analysis.

Regional director Nimfa Torrizo (leftmost) was among the regional directors who presented the maternal and infant health indicators in their regions to then Health Secretary Enrique Ona (fourth from left) during the first Health Leadership and Governance Program Learning Forum. With them were (from left) ZFF trustee David Zuellig and regional director Nestor Santiago.

Where are mothers dying?

Aside from engaging municipalities, ZFF is also working with provincial governments, which have the resources needed to support health programs of municipalities. Of ZFF's 28 provinces, 25 have submitted their reported maternal death cases *(see page 38)*.

Based on the data, it can be inferred that a number of mothers continue to give birth at home, where the environment may not be sterile to ensure safe delivery.

Among the targets of the Foundation's interventions is to increase facility-based delivery so that mothers are given medical attention under the care of skilled health personnel. But the provincial data also showed that most deaths are occurring in hospitals, where complicated birthing delivery cases are referred.

In hospitals, quality care must be given as soon as the patient arrives. And this is possible if hospitals are adequately staffed by specialists and have sufficient blood supply and obstetric medicines. Given the reported number of deaths, the challenge is to ensure hospitals are prepared to handle complicated cases that Rural Health Units and birthing clinics cannot.

But it may also be the case that the mother arrived too late in the hospital to save her life. Determining the factors that led to the death requires the conduct of maternal death reviews.

(See more about home and hospital deaths under "Moving Forward" on page 42).

Maternal Mortality, by Place of Death in 25 ZFF Partner Provinces, 2014*

Home
51 (16%)

In-transit
27 (8%)

Hospital**
236 (72%)

*Partial unofficial data
**There were 6 maternal deaths that occurred in Rural Health Units and/or Barangay Health Stations and 8 deaths in private clinics
Source: Provincial Health Offices

HLGP CHALLENGES

The DOH-ZFF partnership has exhibited signs of success in its second year of implementation. But it is not without risks and challenges. DOH regional directors (RD) identify some of the difficulties they have faced and share some of the strategies they have used to address these:

Frequent change in local leadership

One of the biggest challenges the DOH leadership face is the change in local leadership every three years. "We have to train newly elected mayors if the ones we had trained failed to win the local elections," Balboa said. The new mayor also has to establish ties with the municipal health officer (MHO), whom he has to closely work with for the next three years. In addressing this dilemma, the DOH RDs believe that the training benefits outweigh the risks. "We do not see this as a lost investment, as the trained MHO can provide the continuity needed and act as an advocate to the new administration," Balboa said.

Lack of commitment from the LCEs

Some local chief executives do not make time to attend the training programs from start to finish because of busy schedules, according to Torrizo. Other local leaders, on the other hand, get frustrated upon learning that they would not get any additional funds from the national government after attending the training. The DOH RDs address these by carrying on with the implementation of the HLGP. "I look at it as a regular, capability-building program for LCEs. This ZFF initiative bridged the gap between the DOH and the LGUs brought about by the devolution," Balboa said, adding that the LGU success stories were testaments that the program indeed works if implemented properly. She also noted that the agency gives financial support to LGUs by means of the Health Facility Enhancement Program.

Weak co-ownership from DOH staff

DOH staff should replace their programmatic way of thinking with systems thinking, which is quite a challenge to them since they are used to the "more tangible" provision of services. "It is quite difficult to convince them because systems-thinking is an abstract concept," Cabotaje said. However, the DOH offices are slowly adapting to this new framework. "We now place much importance to coaching and mentoring," she said. "Everybody is becoming part of the entire system." In addition, Santiago has been doing the following: including HLGP updates during Regional Implementation Coordination Team meetings; training all DOH Development Management Officers (DMOs) on Health Leadership and Management for the Poor and Training of Coaches (all LGUs will then receive coaching from their DMOs); establishing regional project management committees for HLGP; involving UP Manila-College of Public Health, an academic partner for Region IV, during site monitoring visits; and hiring project assistants to focus on HLGP.

Getting the buy-in of key DOH stakeholders

Stakeholders in the DOH central and regional offices still prefer the programmatic way of doing things. Instead of strengthening the health system as a whole, there is still a focus on specific programs and the old way of doing things: allot the budget, provide the logistics, and leave the LCEs to do things on their own. "There is a need for a paradigm shift and to look at the different health components as part of a bigger system," Sobrepeña said. Santiago, on the other hand, sees advocacy of the HLGP during executive committee meetings at the DOH central office and the engagement of key stakeholders as significant ways to address this risk.

Budget allocation for HLGP

Since the HLGP is still considered a project, allocating a permanent budget for it remains a challenge. There has to be a line item approved by the Department of Budget and Management, Sobrepeña explained, "The challenge for us is how to institutionalize it," she said. In the meantime, Santiago ensures the budget for the HLGP from the Local Health Systems and Development Assistance funds.

Training capacities of Academic Partners

The program introduced most faculty members to a relatively new leadership framework, the bridging leadership (BL). As training providers, faculty members must also go through the rigor of attending different ZFF capability-building programs to deepen their understanding and appreciation for BL in helping local health leaders address the inequities in their local health systems. By the end of 2014, a number of faculty members still needed to sharpen their skills in handling difficult training sessions, coming up with training designs, and overseeing quality control. There is also a need for the academic institutions to develop their own training materials suited to their local conditions.

Make leadership and governance a regular course offering in the APs

Academic institutions are also encouraged to make the health leadership and governance program a regular course offering. This would entail crafting a plan that spells out the cost structures, quality check systems, and materials and manpower requirements. Having this business plan would ensure that the program can be given to more leaders in the different regions beyond the DOH-ZFF partnership term.

"HLGP (Health Leadership and Governance Program) is like a train. As it moves along, it takes on one program at a time. At the first station, MNCHN (Maternal, Neonatal and Child Health and Nutrition) gets in. Next stop, NTP (National Tuberculosis Control Program) hops in. Then EPI (Expanded Program on Immunization)...eventually, when the train reaches its final destination, KP (Kalusugang Pangkalahatan (Universal Health Care program) has been realized."

Dr. Nestor Santiago, Jr.,
Regional Director, DOH Regional Office IV-A (CaLaBaRZon)

MATERNAL HEALTH STATISTICS PER REGION*
LGUs with "Municipal Health Leadership and Governance Program" (MLGP)

Region	No. of LGUs with MLGP	No. of LGUs with '12-'14 data	MATERNAL DEATHS 2012	2013	2014	MMR 2012	2013	2014
CAR	34	23	4	5	1	61.5	75.2	16.0
I	19	19	4	3	0	51.3	33.9	0
IV-A	22	15	8	6	7	63.9	49.2	69.0
IV-B	32	29	23	21	26	86.4	79.5	125.5
V	46	46	33	42	66	70.5	92.3	154.4
VI	30	7	3	5	0	58.9	123.9	0.0

*Partial unofficial data
Sources: Municipal and Regional Field Health Services Information Systems

Region	No. of LGUs with MLGP	No. of LGUs with '12-'14 data	MATERNAL DEATHS 2012	2013	2014	MMR 2012	2013	2014
VIII	29	16	5	5	4	72.4	83.4	63.4
Region	No. of LGUs with MLGP	No. of LGUs with '12-'14 data	MATERNAL DEATHS 2012	2013	2014	MMR 2012	2013	2014
IX	36	36	18	11	18	70.4	45.2	70.7
Region	No. of LGUs with MLGP	No. of LGUs with '12-'14 data	MATERNAL DEATHS 2012	2013	2014	MMR 2012	2013	2014
X	51	32	15	19	24	64.7	86.1	109.1
Region	No. of LGUs with MLGP	No. of LGUs with '12-'14 data	MATERNAL DEATHS 2012	2013	2014	MMR 2012	2013	2014
XI	32	10	8	11	20	64.5	90.0	188.8
Region	No. of LGUs with MLGP	No. of LGUs with '12-'14 data	MATERNAL DEATHS 2012	2013	2014	MMR 2012	2013	2014
XII	39	38	50	41	40	86.7	73.7	70.3
Region	No. of LGUs with MLGP	No. of LGUs with '12-'14 data	MATERNAL DEATHS 2012	2013	2014	MMR 2012	2013	2014
XIII	28	28	23	22	40	106.9	104.0	199.1

Onward to quest for improved health outcomes

In 2008, the Foundation decided to implement a health change strategy to improve local health systems because this is the most accessible to the poor.

Among the objectives was to help the country achieve its health targets under the Millennium Development Goals (MDGs), including the maternal mortality ratio (MMR), which proved difficult to reduce. The deadline to achieve the MDGs is by the end of 2015.

Fast forward to the end of 2014 and it has been projected that the Philippines will not to meet its MMR target of 52 by 2015. As of 2011, the number was quadruple the target at 221. These figures show that maternal mortality remains a continuing challenge for the Philippines.

ZFF recognizes that reducing maternal deaths entails fixing the entire system, starting with the local health leadership. The mayors and governors, after all, have been heading the local health systems in the last two decades, following the passage of the Local Government Code of 1991. The Code had then specified the devolution of health services from the Department of Health (DOH) to the local government units (LGUs).

The Foundation utilizes its "Health Change Model" strategy to help health leaders in producing better health outcomes, with a special focus on maternal mortality, as it is a sentinel indicator on the quality of the health system.

This strategy is also employed in ZFF's partnership program with the Department of Health. The partnership was forged in May 2013. At the end of that year, 15 DOH regional offices provided maternal death statistics. Total reported deaths from the reporting regions reached 1,126.

WHY ARE MOTHERS STILL DYING GIVING BIRTH?

Of these deaths, 439 cases were reviewed for causes of deaths and showed that the most common cause, at 46 percent of total, was obstetric hemorrhage or excessive bleeding.

Of the 1,126 maternal deaths, 545 cases had identified places of deaths. Most deaths, at 68 percent, occurred in hospitals *(see chart on page 45)*.

An analysis of the deaths in the regions was made based on the "Three Delays Model"*—a framework used to understand the reasons why women die from treatable pregnancy-related complications.

FIRST DELAY: DELAY IN SEEKING CARE

In an ideal municipal health system, barangay health workers (BHWs) identify every pregnant mother in their assigned villages. A midwife then provides these pregnant mothers with prenatal care and health facilities-based delivery. If a pregnant woman is classified as high-risk (for reasons such as first pregnancy or primigravida, has had over four pregnancies, or is hypertensive), the mother is referred to a hospital for more intensive care.

However, 18 percent of the maternal deaths occurred at home. Why?

The partner municipalities of ZFF provide a telling clue. When asked why some women prefer delivering at home under the care of *hilot* (traditional birth attendant), their common answers were: *pumutok na ang panubigan* (water broke), *walang pera* (no money), *malayo ang health center at walang matutuluyan sa may health center* (there is no place to stay near the health center that is also too far).

In poor municipalities, the following factors result in mothers dying during childbirth at the hands of the *hilots*: poverty, low education, homes in distant areas, and traditional health seeking behavior. BHWs in these poor areas do not necessarily track every pregnant woman. Midwives, who may be limited in number, could not conduct prenatal checks on pregnant women who live far from the health facility. Rural Health Units (RHUs) could no longer monitor the high-risk mother after she has been referred to a hospital. The mothers themselves get intimidated by these referrals—without the money, resources and connections, these pregnant women choose to give birth in their "comfort setting" (home) with familiar caregivers (*hilots*).

* Introduced by Sereen Thaddeus and Deborah Maine in their 1994 paper, "Too far to walk: maternal mortality in context."

The following interventions implemented under the ZFF and United States–Philippines Society post-typhoon Haiyan (local name: Yolanda) partnership—"Recovery Assistance Program for Mothers—can be applied to address first delay issues: giving incentives to BHWs to identify all pregnant mothers, and providing financial support to pregnant women to defray prenatal, birthing and post-natal care costs.

Other interventions include building maternal homes beside birthing clinics, allowing local birthing rituals as long as these are held in health facilities, enrolling indigents in Philippine Health Insurance Corp. (PhilHealth), ensuring the public health facilities are PhilHealth-accredited, and using technology to record health indicators and track pregnant women.

The "Wireless Access for Health" (WAH) technology works by sending reminders to the mobile phones of pregnant mothers and midwives in cases of missed checkups. Aside from pregnancy tracking system, municipalities must also conduct regular maternal death reviews.

Information from these systems must then be consolidated, organized and reported by relevant public health agencies. No plans and programs will be effective without up-to-date and quality data.

Most important of all, the mayors need to "own" the good maternal health of their constituents and to address the gaps in their local health systems.

SECOND DELAY: DELAY IN REACHING CARE

The death in transit entails a mother dying en route to the RHU or the hospital. Of the deaths in the different regions, three percent (3%) occurred in transit.

Delay in reaching medical care occurs when a mother who initially decided for a home delivery is advised by a *hilot* to go to the RHU after finding the delivery difficult to handle. Or in the RHU, a mother gets referred to a hospital because of complications arising from her pregnancy or her delivery.

Second delay issues can be addressed if a proper referral system between the RHU and hospital is in place. This means prior coordination is made with a pre-determined CEmONC (Comprehensive Emergency Obstetric and Newborn Care) referral hospital such that the hospital knows the mother's medical history and upon admission, the mother receives critical care within 24 hours.

Emergency transport vehicles must always be available, including sea or river ambulance for geographically isolated and disadvantaged areas.

Provision for accommodation arrangements for the mother's companions must also be seriously considered.

THIRD DELAY: DELAY IN RECEIVING QUALITY CARE

As stated earlier, 68 percent or most of the deaths occurred in hospitals. What factors could have led to the deaths?

ZFF, which also works with provincial governments, identified 10 provincial hospitals with high reported maternal deaths in 2013 and 2014. The following reasons were noted in their maternal death reviews: mothers arriving at the facility too late, so nothing else can be done to save their lives; and ill-equipped hospitals failing to address emergency cases even if the mothers had arrived on time.

Location: Mandaon, Masbate

A separate assessment conducted in 2014 by chiefs of hospitals of 36 CEmONC designated provincial hospitals and one DOH CEmONC hospital revealed these challenges: the unavailability of blood and medical specialists on a 24/7 basis; absence of "no balance billing" policy; and lack of medicines.

While every province must have at least one CEmONC-capable hospital, these hospitals must have blood, specialists and medicines available at all times. "No balance billing" must be implemented for poor patients.

Establishing a provincial blood network could ensure the availability of blood at all times. Each hospital must also be able to accurately determine its blood requirement so that there is timely stock replenishment. It would be most useful if blood centers' inventory systems allow hospitals to get updated on available stocks of blood.

ZFF began working closely with the DOH to address the blood supply problem. A technical conference involving regional blood coordinators traced the roots of the problem and the possible remedies. ZFF is overseeing the fulfillment of agreed milestones during the conference.

In addressing provincial hospital issues, particularly the allocation of financial resources, the leadership of governors is important. ZFF's intervention at the provincial level aims to help governors assess the reliability of their hospitals in handling both critical obstetric cases such as caesarian and non-obstetric-related complications.

WHAT MORE SHOULD BE DONE TO REDUCE MMR?

FOCUS ON FAMILY PLANNING

There is an urgent need to address the challenges of mothers with unmet family planning (FP) needs. Mothers who want to space their children should be given access to information and FP approaches and commodities. According to the 2013 National Demographic Health Survey (NDHS) involving married couples not using any FP methods, 80 percent had no discussion about family planning with health personnel during their visits to health facilities. The same survey showed that while total demand for FP was 73 percent, unmet need for family planning among married women reached 18 percent.

A 2012 Johns Hopkins study revealed that contraceptive use could cut maternal deaths in the country by as much as 54 percent. High-risk mothers should have the option of not getting pregnant. Based on ZFF's 2014 data from its partner-municipalities, of 94 maternal death cases, 36 percent occurred among those who have had five or more pregnancies. And of 102 death cases reported in its partner-municipalities, 39 percent was among

Tawi-Tawi Provincial Hospital

high-risk mothers—30 percent among those 35 years old and above and 9 percent among mothers below 19 years old.

In 2015, the Foundation will begin rolling out its program to increase access to modern family planning methods. To be introduced in its partner-municipalities, the program aims to increase contraceptive prevalence rate, reduce unmet needs for FP, and cut down pregnancies among adolescents or those below 19 years of age.

LOOKING AHEAD

Aside from the specific 2015 plans, the Foundation is also gearing itself up for the next decade. As it begins the process of charting its strategic direction in the next 10 years beginning 2016, ZFF will face a host of challenges that will test its capacity to maintain its relevance in a rapidly changing environment. It will have to ensure its competitiveness, effectiveness and the impact of its interventions in a future fraught with possibilities and uncertainties.

The deadline for the Millennium Development Goals will be at the end of 2015. These will be replaced by a new set of targets under the Sustainable Development Goals. In Southeast Asia, there will be a forthcoming integration of the Association of Southeast Asian Nations. And while the Foundation has identified the rural poor as the primary target of its interventions, the reality is that urban population in the country has been growing. Based on the 2010 census, urban to total population was at 45.3%. It was 42.4% in 2007. Urbanization poses challenges that adversely affect health, especially of the poor. Among these are high cost of living, congestion and informal settlements where health and sanitation facilities are lacking.

STILL HEALTH FOR THE POOR

These ongoing and upcoming developments will have an impact on the directions the Foundation will take in the years to come. ZFF, however, sees itself still being guided by its vision of being a catalyst for the achievement of better health outcomes for the poor.

With most home births under the care of non-skilled attendants continuing and leading to deaths, there remains a need to further strengthen primary healthcare systems. And with other factors like education and livelihood affecting health, ZFF can help municipalities by mobilizing partners who can address these other social determinants of health.

Threats of natural calamities also make ZFF's ongoing assistance for the development of resilient municipal health systems relevant to other areas in the country.

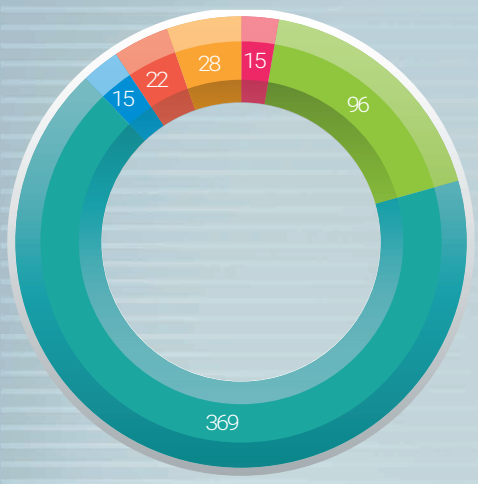
Since most deaths are occurring in hospitals, ZFF will continue its provincial-level leadership and governance interventions to address challenges faced by hospitals and help fix referral systems between RHUs and hospitals.

The partnership with the DOH will formally end in 2016, but the Foundation hopes the partnership will continue.

These broad future plans require ZFF to continue offering its interventions to local governments. It may need to establish its presence as a learning institute in areas where there are no academic partners to provide the health leadership and governance training.

ZFF will continue to ensure the integrity of its interventions through a quality assurance system. Through knowledgeable and dedicated facilitators, and using inspiring and up-to-date materials, ZFF will provide high-quality leadership and governance interventions to leaders—mayors, governors, and the DOH—in order to realize better health outcomes for the poor.

MATERNAL MORTALITY, BY PLACE OF DEATH, END-2013



PLACE OF DEATH	MATERNAL DEATHS	
	ABSOLUTE NO.	%
Hospital	369	68
Home	96	18
Not Specified	28	5
Others	22	4
RHU/BHS	15	3
In-transit	15	3
Total	**545**	**100**

Source: DOH Regional Offices

THE ZUELLIG FAMILY FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE

	December 31	
	2014	2013
ASSETS		
Current Assets		
Cash and cash equivalents	**₱109,787,043**	₱119,462,277
Receivables	**3,758,173**	236,631
Prepaid and other current assets	**745,853**	618,238
Total Current Assets	**114,291,069**	120,317,146
Noncurrent Assets		
Property and equipment	**10,184,021**	10,829,899
Retirement asset	**231,351**	824,923
	10,415,372	11,654,822
	₱124,706,441	₱131,971,968
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accrued expenses and other payables	**₱41,181,674**	₱29,363,153
Deferred revenue	**–**	18,355,451
Due to a related party	**439,669**	63,345
Total Current Liabilities	**41,621,343**	47,781,949
Fund Balance	**83,085,098**	84,190,019
	₱124,706,441	₱131,971,968

See accompanying Notes to Financial Statements.

The complete audited financial statement report can be found in the CD.

THE ZUELLIG FAMILY FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF REVENUES, EXPENSES AND FUND BALANCE

	Years Ended December 31	
	2014	2013
REVENUES		
Donations	**₱176,314,216**	₱137,492,538
Reversal of accrual of retirement costs	**–**	6,865,002
Interest	**654,010**	1,211,266
Others	**6,990**	6,865
	176,975,216	145,575,671
EXPENSES		
Professional fees	**40,599,041**	21,995,416
Donations and contributions	**28,171,263**	27,946,806
Trainings and seminars	**27,021,404**	20,784,012
Transportation and travel	**25,256,227**	15,734,881
Salaries, wages and other benefits	**19,943,887**	15,779,963
Infrastructure projects	**17,307,124**	23,254,801
Utilities	**6,827,570**	4,435,459
Depreciation and amortization	**5,362,994**	4,721,560
Materials and supplies	**4,214,626**	4,099,464
Representation and entertainment	**1,558,952**	1,505,831
Retirement costs	**593,572**	–
Unrealized foreign exchange losses (gains)	**66,300**	(30,714)
Others	**1,157,177**	1,050,295
	178,080,137	141,277,774
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	**(1,104,921)**	4,297,897
FUND BALANCE AT BEGINNING OF YEAR	**84,190,019**	79,892,122
FUND BALANCE AT END OF YEAR	**₱83,085,098**	₱84,190,019

See accompanying Notes to Financial Statements.

ZUELLIG FAMILY FOUNDATION
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Chairman

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Executive Assistant

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President

JESSIE MARIE PASCUA
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RAMON R. DERIGE
Vice President

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Director

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Manager

TERESA FABUGAIS, MPM
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Assistant

This Annual Report was printed on the Forest Stewardship Council (FSC)-certified paper. In an effort to reduce the consumption of resources from printing and distributing hard copies, an electronic copy of this report and the complete 2014 audited financial statements are contained in the CD. The Report may also be downloaded from our website, www.zuelligfoundation.org.

ZUELLIG FAMILY FOUNDATION

Duly certified as a development agency by the
Department of Social Welfare and Development (DSWD)
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